MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

January 16-17, 2002

Updating payments for outpatient dialysis services for 2003

ISSUE: Are payments for outpatient dialysis services adequate? Should the composite rate be updated for 2003?

KEY POINTS: Medicare's payments for outpatient dialysis services do not appear to be inadequate based on the following evidence:

- Medicare's payment for composite rate services averaged four percentage points less than the costs incurred by freestanding dialysis facilities in 2000. However, Medicare's payments exceeded providers' costs by five percentage points in 2000 when we considered payments and costs for both composite rate services and separately billable injectable drugs.
- Our review of trends in providers' costs for composite rate services suggests that costs are appropriate. The significant increase in the use of injectable medications between 1997 and 2000, their positive payment margin, and evidence that some of these medications may not be provided efficiently suggests that Medicare's payments for injectable medications is too high.
- Broad indicators of the financial health of the dialysis industry suggests that total outpatient dialysis payments are adequate.

The Commission's update framework accounts for expected cost changes in the coming year primarily through the forecast of input price inflation. MedPAC's index for dialysis services indicates that the prices facilities pay for their inputs included in the composite rate will rise an estimated 2.6 percent between calendar years 2002 and 2003.

Based on our analysis of payment adequacy and expected cost changes in the coming year, staff propose that the Commission recommend that the Congress update the composite rate by 2.6 percent to account for changes in input prices in calendar year 2003.

ACTION: Commissioners should discuss the tone, findings, and draft recommendation about updating the composite rate in 2003. The Commission's recommendation about updating payments for dialysis services will be included in the March 2002 report.

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MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

January 16-17, 2002

Payment adequacy and update: skilled nursing facility care

ISSUE: Is the current base payment rate (pool of money available) adequate for skilled nursing facility (SNF) care? Are payments distributed appropriately? At what rate should payments be updated for 2003?

KEY POINTS: To assess whether the base rate is adequate, we consider the relationship of payments to costs, whether costs are appropriate, and other indicators of adequacy of payments. Because of uncertainty regarding whether CMS will refine the RUG-III classification system and eliminate the temporary payment add-on, we consider payment adequacy with and without the add-on in effect.

- The relationship of estimated payments and costs for 2002 suggests that, with the payment add-on in effect, overall payments appear to be adequate. Without the add-on, payments appear to be inadequate.
- Current estimated costs are most likely overstated, however.
- Other indicators we examined suggest that the base rate is probably adequate: freestanding SNFs have stayed in the Medicare program, beneficiaries have had stable access to SNF care in 2000 and 2001, and most SNFs appear to have access to capital.
- We expect SNFs to continue adjusting to the PPS in FY 2003, by finding additional ways to reduce costs and become more efficient.

To assess whether payments are distributed appropriately between freestanding and hospital-based SNFs, we evaluate costs for both freestanding and hospital-based SNFs, considering the relationship of payments to costs, whether costs are appropriate, and other indicators by type of SNF.

- Payments, with the one add-on in effect, appear to be more than adequate for freestanding SNFs; for hospital-based SNFs, they appear less than adequate. Continuing exit from the Medicare program and negative margins beyond what we would expect even after their costs are adjusted also suggest payments are not adequate for hospital-based SNFs.
- The maldistribution of payments results in part from the RUG-III's inability to differentiate among patients adequately. Hospital-based SNFs have had a substantially higher case-mix index—11 points higher than freestanding SNFs in 1999—and appear to furnish a different product. These differences are not necessarily reflected in their payments.
- An inappropriate distribution of payments that results from the classification system ideally should be addressed by fixing that system. However, CMS faces substantial obstacles in refining the RUG-III successfully and a new classification will be available no earlier than 2006. Therefore we recommend a less than optimal remedy—different updates for freestanding and hospital-based SNFs.

Based on the above information, we present a draft recommendation for updating SNF payments for FY 2003 that has multiple parts.

ACTION: At this meeting, Commissioners will discuss and vote on the draft recommendation for updating payments for SNF care.

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MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

January 16-17, 2002

Assessing payment adequacy and updating payments in the home health prospective payment system

ISSUE: Are current payments adequate? How much will efficient providers' costs grow over the next year? The answers to these two questions will form the basis of our update recommendation for home health as well as our response to two imminent payment changes—the implementation of the so-called 15 percent cut in the PPS base rate and the sunset of the 10 percent payment add-on for home health services delivered to rural beneficiaries.

KEY POINTS: What we do know and what we do not know is mixed in roughly equal parts in our analysis of this sector. We do know that declines in spending and use of home health services between 1997 and 1999 were substantial. We do not, however, have an estimate of the current level of costs and payments. Market conditions—good access to care, stable exit and entry of providers— provide no evidence of a current, significant disparity between payments and costs.

In the absence of compelling evidence of either current disparity or of factors that would cause providers' costs to grow at a rate different from input price growth, we would recommend an update equal to the forecasted change in the home health market basket. However, given the high level of uncertainty in this sector, the stabilizing option may be to follow expectations and concur with current law, which is an update of market basket minus 1.1 percent.

An additional reduction in the base is scheduled for October 2002. Since the intended outcomes of the legislation of which the cut is the last phase have been largely achieved already, the cut may no longer be appropriate.

Another area where we could recommend stability instead of change is the imminent sunset of the 10 percent add-on for rural home health services. An extension of the policy by two years may allow time for better data to become available and to develop a sense of the impact of the additional payments.

ACTION: Staff asks the Commissioners to discuss and vote on draft recommendations on the update factor, the 15 percent cut, and the rural add on.

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